Points to Consider:

- Clarify whether gastroenteritis is infectious (bacterial or viral) or non-infectious and documented associated organism, if known.
- Document any associated dehydration or hypotension with gastroenteritis.
- Clarify if fever is suspected to be bacterial, viral or other (e.g., leukemia) in origin.
- Inflammatory bowel disease is symptomatic of underlying conditions. Specify the intended diagnosis (e.g., Crohn's disease, ulcerative colitis or pancolitis). If Crohn's disease or ulcerative colitis is appropriate, document any associated complications such as rectal bleeding, intestinal obstruction, fistula and abscess as well as location of disease.
- "SIRS due to an infection." Clarify if patient has sepsis (systemic infection) or a localized infection.
- Do not document the term "urosepsis." Instead clarify if the patient has a UTI or sepsis.
- Document any conditions that occur intraoperatively or postoperatively. Additionally, document a cause-and-effect relationship (or lack thereof) between the procedure and the condition and that the condition is a complication or an expected outcome.

Medical Record Completion Requirements

- **H&P**: Must be completed within 24 hours following admission, but prior to surgery. Needs to include the chief reason for admission and all pertinent diagnoses and conditions that are present on admission. Include all signs and symptoms the patient is experiencing.
- **Operative report**: Must be completed within 24 hours of procedure and include a full description of procedure and any intra-operative or postoperative complications, if known.
- **Discharge summary**: Needs to include the final principal diagnosis, all secondary diagnoses which were clinically significant for the current hospitalization including all conditions that were resolved and each procedure performed. Also include indication if plan for readmission.

Definitions Important for Complete Documentation

- **Principal diagnosis** is that condition established *after study* to be *chiefly responsible* for occasioning the admission of the patient to the hospital for care.
- **CC:** Comorbidity/Complication
- **Comorbidity:** A pre-existing condition present at the time of admission which may cause an increase in the length of stay
- **Complication:** a condition that arises during the hospital stay that may prolong the length of stay
- **MCC:** Major Comorbidity/Complication
- **POA**: Present on Admission
- **HAC**: Hospital Acquired Condition
- **ROM:** Risk of Mortality
- **SOI:** Severity of Illness

Common Severity/Mortality Drivers

- Acute blood loss anemia
- Acute renal failure (indicate underlying cause)
- Electrolyte imbalances (hypo/hypernatremia, hypo/hyperkalemia, hypo/hypermagnesemia, hypo/hypercalcemia)
- Encephalopathy (specify type, acuity and cause)
- End stage renal disease (specify underlying cause)
- Gastrointestinal hemorrhage (document acuity and link to site of bleed)
- Heart failure (specify acuity and type)
- Hemiparesis (specify cause and laterality)
- Hypotension (specify cause)
- Ileus
- Malnutrition (specify severity)
- Metastases to bone, brain, liver, lung, lymph nodes
- Sepsis
- Urinary tract infection (specify site of infection such as bladder, kidney, or urethra)

GASTROENTEROLOGY

DOCUMENTATION IMPACTING MS-DRG & APR-DRG ASSIGNMENT AND SEVERITY/MORTALITY PROFILES

Dear Doctor, Please note that the Clinical Terms and Diagnostic Statements referenced are examples only, and in no way intended to lead the physician to any particular diagnosis. Your independent clinical judgment and documentation is the ultimate source of reference in the medical record.

A patient's Severity of Illness (SOI) and Risk of Mortality (ROM) is determined by the diagnostic terminology expressed in the medical record. Documentation must be accurate, complete and specific.

Basic Physician Documentation Requirements

- Document the reason(s) for the inpatient admission and the complex medical judgment factors to be considered including the severity of the signs and symptoms and the medical predictability of something adverse happening to the patient whenever possible to provide appropriate substantiation for severity of illness and risk of mortality.
- For all medications, treatments, and diagnostic studies, document the corresponding medical diagnoses indicating the clinical significance of the diagnosis. A code may not be assigned based on abnormal laboratory results or diagnostic report findings alone.
- Document all conditions including probable, suspected, or questionable based on your independent professional judgment and the clinical evidence and treatment provided. Clearly document if a condition was ruled out or was still considered probable at the time of discharge. Documentation should include the medical decision making process and supportive clinical information.
- Document all conditions still present, though possibly compensated or controlled, if they are currently being monitored, evaluated, treated, or causing increased nursing care or length of stay. These diagnoses should be listed as current medical conditions.
- Remove diagnoses from the problem list that are not clinically significant or have been ruled out.

3M

Clinical Terms (Needs clarification)	Diagnostic Statement (Accurate code may be assigned)
Abdomen distended, tender	Specify diagnosis being treated even if considered probable or suspected such as ascites, ileus, fecal impaction, obstruction, peritonitis
Gastroenteritis	Document etiology when known or suspected (e.g., infectious vs. non-infectious); if infectious, document organism, if known or suspected, or due to bacteria, virus or food borne; if non-infectious, document cause such as radiation, drug-induced, allergic or due to food hypersensitivity
Hgb 6.8, Hct 27.5, will transfuse	**Anemia** (specify type, if known or suspected, such as acute or chronic blood loss anemia, anemia of chronic disease, hemolytic anemia, iron deficiency anemia, pernicious anemia)
Coffee ground emesis	**GI hemorrhage** (specify acuity, site and lesion type, if known or suspected, such as acute gastric ulcer with hemorrhage, diverticulitis with hemorrhage)
Rectal hemorrhage, history of diverticulosis, anemia	**Diverticulosis with hemorrhage** (link the condition to the hemorrhage); **blood loss anemia** (specify if acute or chronic)
Bleeding esophageal varices	Link esophageal varices to underlying cause, if known or suspected, such as cirrhosis or portal hypertension
Chest pain, noncardiac, treated with NSAID and H2-blockers	Specify diagnosis being treated even if considered probable or suspected such as **chest wall pain, GERD, esophagitis, costochondritis**

Clinical Terms (Needs clarification)	Diagnostic Statement (Accurate code may be assigned)
Abdominal pain, increased lipase and amylase	**Pancreatitis** (specify acuity such as acute or chronic; specify etiology such as idiopathic acute pancreatitis or alcohol induced acute pancreatitis)
POD #3, lack of bowel sounds, abdominal distention, remains NPO, re-insertion of NG tube, ordered Reglan, delayed discharge	**Ileus** (document if condition is a complication of the prior surgery or is an expected outcome)
Hemorrhoids	Document degree (first, second, third or fourth); if bleeding is present, document if bleeding is due to hemorrhoids or due to some other problem
Encephalopathy	Specify type, if known or suspected, such as alcoholic encephalopathy, hepatic encephalopathy, hypertensive encephalopathy, metabolic encephalopathy, toxic encephalopathy
Hepatic failure/hepatic encephalopathy	Specify acuity (acute, subacute, chronic), document presence of hepatic coma, document etiology (alcohol, drugs, hepatitis C, cirrhosis)
Colon or gastric mass, weight loss, abdominal pain	**Neoplasm** (specify benign, malignant, primary, secondary; document location such as ascending colon, transverse colon, fundus of stomach, pylorus)
Patient with metastasis	Document site of primary cancer (and if it is still present); individually list all secondary sites. Example: Metastatic cancer to the left lower lobe lung from the left upper quadrant breast

Clinical Terms (Needs clarification)	Diagnostic Statement (Accurate code may be assigned)
Emaciated, ↓ albumin, weight loss, BMI 16.5, nonhealing wounds, nutritional consult, ordered supplements, consider TPN	**Malnutrition** (specify type such as protein calorie, protein energy; document severity such as mild, moderate or severe or first, second or third degree)
↓BP, hemodynamically unstable, IV fluid bolus started, dopamine ordered	**Shock** (specify type such as cardiogenic, septic, hypovolemic); **hypotension** (specify type such as chronic, drug-induced, iatrogenic, idiopathic, intra-dialytic, orthostatic, postoperative)
Dry mucus membranes, poor skin turgor, will rehydrate patient	**Dehydration**
Continue home medications such as nitrates, beta-blockers, furosemide, phenoytoin	Document specific diagnosis such as **CAD, atrial fibrillation, chronic systolic heart failure, angina, HTN, seizure disorder**
Diabetes, blood sugar ↑360, will start insulin drip, history of PVD	Specify type (type 1, type 2, drug or chemical induced, other underlying condition), document any associated complications (diabetic autonomic neuropathy, diabetic foot ulcer, PVD due to diabetes – must document a cause and effect link), document insulin control status as controlled, out of control, with hyperglycemia
Obesity, BMI 40.4	Document etiology such as due to excess calories, nutritional, due to drugs, due to thyroid disorder, due to pituitary disorder